Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13072

6 - MD NOTES

[redacted]

HISTORY AND PHYSICIAL EXAMINATION

[redacted]

Patient Identification

Date of Exam: 8/21/97 **Time:** 1145 AM / PM

MEDICAL HISTORY:

MAJOR ILLNESSES: PAST - none significant

PRESENT -

SURGICAL HISTORY: none

TRAUMA: none

MEDICATIONS: none

ALLERGIES: NKDA

SUBSTANCE USE:

ETOH: ø

COCAINE: ø

CANNABIS: ø

OPIATE: ø

NICOTINE: ½ PPD - 1½ yr

BENZODIAZEPINES: ø

PCP: ø

LSD: ø

STIMULANTS: ø

DEPRESSANTS: ø

OTHER: ø

SIGNIFICANT SOCIAL ISSUES CONTRIBUTING TO CONDITION:

degrami / family problems

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[redacted]

HISTORY AND PHYSICAL EXAMINATION

SIGNIFICANT FAMILY PSYCHIATRIC / MEDICAL HISTORY: Dad - migraines
Mom - Cerebral palsy, 15m - fmr
uncle → depression
9th grader.

REVIEW OF SYSTEMS:

GENERAL: fine
INTEGUMENT: knuckle hunting - abrasions (tetanus last yr)
HEENT: allergies/seasonal
BREASTS: denies
RESPIRATORY: denies
CARDIOVASCULAR: denies
GASTROINTESTINAL: denies
GYNECOLOGICAL: LMP 8/6/98
GENITOURINARY: denies
OBSTETRICAL: G0P0
MUSCULOSKELETAL: denies
NEUROLOGICAL: denies
ENDOCRINE: denies
LYMPHATIC: denies
HEMATOLOGIC: denies

PHYSICAL EXAM:

VITAL SIGNS: BP 82/64 P 85/bt R 18/bt TEMP 97.8 HT 5'3" WT 110 lbs

GENERAL APPEARANCE:

☑ INSPECTION: Patient is well-developed, well-nourished individual who does not appear to be acutely or chronically ill. Posture is appropriate, no visible disturbance of gait.

☐ SPECIFY OTHERWISE:

SKIN:

☑ PALPATION: Warm, moist, elastic.

☑ INSPECTION: Without significant eruptions or discoloration.

☐ SPECIFY OTHERWISE:

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HISTORY AND PHYSICIAL EXAMINATION

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Patient Identification

HEAD:

☑ INSPECTION: Scalp is clean. Hair is of normal distribution of color.

☐ SPECIFY OTHERWISE:_____

FACE:

☑ INSPECTION: Facial countour, mobility, and expression are normal. No marked asymmetry or sagging is noted.

☐ SPECIFY OTHERWISE:_____

Acne (+)

EYES:

☑ INSPECTION: Pupils are equal, round, regular, and react to light and accommodation. Extraocular movements are normal. The sclera is white. Conjunctivae are free from infection. The cornea and lens are clear. The fundoscopic examination reveals sharp disc margins. Vessels are of normal caliber. No hemorrhages or exudates.

☐ SPECIFY OTHERWISE:_____

NOSE:

☑ INSPECTION: No obvious deformity. Mucous membranes are not inflamed. Turbinates are not swollen. Air ways are patent. There is no septal perforation.

☐ SPECIFY OTHERWISE:_____

EARS:

☑ INSPECTION: Canals are clear. Tympanic membranes intact and noninjected. Hearing is adequate for normal conversation. Auricles are free from tophi or other abnormalities. Wever_____ Rinne_____

☐ SPECIFY OTHERWISE:_____

MOUTH:

☑ INSPECTION: No unusual breath odors. There is no significant change in the color or texture of the lips, tongue, or buccal membrane. Tongue protrudes in the midline without unusual tremor. Teeth are in good repair and the gums appear healthy.

☐ SPECIFY OTHERWISE:_____

PHARYNX:

☑ INSPECTION: Mucosa is not inflamed. No evidence of swelling or exudate. Tonsils are present and not enlarged.

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☐ SPECIFY OTHERWISE:_____

[redacted]

HISTORY AND PHYSICAL EXAMINATION

THYROID:

☑ INSPECTION / PALPATION: The thyroid is not enlarged and there are no nodules.

☐ SPECIFY OTHERWISE:

NECK:

☑ INSPECTION / PALPATION: There is no limitation of lateral, anteroposterior or rotating motion. Trachea is midline.

☐ SPECIFY OTHERWISE:

GLANDS:

☑ INSPECTION: There is no significant lymph gland enlargement in the neck, axillae, epitrochlear area, supraclavicular area or groin.

☐ SPECIFY OTHERWISE:

CHEST:

☑ INSPECTION: Normal contour and movement on inspiration / expiration.

☐ SPECIFY OTHERWISE:

LUNGS:

☑ AUSCULTATION: Breath sounds are audible. No rales, rhonchi, or wheezes are noted.

☑ PERCUSSION: Resonant in all fields.

☐ SPECIFY OTHERWISE:

BREASTS:

☐ INSPECTION / PALPATION: Free from masses and tenderness, discharge, dimpling, wrinkling or discoloration of the skin.

☐ SPECIFY OTHERWISE: Not done

HEART:

☑ INSPECTION: Not enlarged to percussion.

☑ AUSCULTATION: Heart sounds are regular in rhythm and of normal rate. No murmurs, thrills, clicks, or rubs.

☐ SPECIFY OTHERWISE:

ABDOMEN:

☑ INSPECTION / PALPATION: Normal contour, no masses or tenderness, no palpable organomegaly (kidney, liver, spleen). There is no costovertebral angle tenderness. No guarding.

☑ PERCUSSION: No tympany nor free fluid.

☑ AUSCULTATION: Peristaltic sounds audible in four quadrants. No bruits.

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☐ SPECIFY OTHERWISE (Include Scars):

[redacted]

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HISTORY AND PHYSICIAL EXAMINATION

[redacted]

Patient Identification

SEXUAL HISTORY:

☐ CIRLCE WHAT APPLIES: Heterosexual Homosexual Sexually Active

☐ NO HISTORY OF SEXUALLY TRANSMITTED DISEASES

☐ SPECIFY OTHERWISE: Not active

GENITALIA / PELVIC - FEMALE:

☐ INSPECTION / PALPATION: No hernia. No lesions of the labia or introitus are noted. The vaginal mucosa is moist and normally elastic. Uterus is normal size, shape, position, freely movable. Cervix is without lesions. There is no significant vaginal discharge.

☐ SPECIFY OTHERWISE: _____

DATE / RESULT OF LAST PELVIC EXAMINATION: _____

DATE / RESULT OF LAST MAMMOGRAPHY: _____

If not performed:

☑ PATIENT IS LESS THAN 18 AND NOT SEXUALLY ACTIVE.

☐ RECENT EXAM COMPLETED ON _____ BY _____

☐ PATIENT WISHES TO HAVE OWN INTERNIST OR GYNECOLOGIST PERFORM EXAM.

Physican's Name: _____

☐ PATIENT UNABLE TO COOPERATE BECAUSE OF PSYCHIATRIC CONDITION; EXAM DEFERRED UNTIL (Date): _____

☐ SPECIFY OTHERWISE: _____

GENITALIA - MALE:

☐ INSPECTION / PALPATION: Both testes palpable. No abnormal masses. No hernia. No urethral discharge. No lesion of glans or shaft noted.

☐ SPECIFY OTHERWISE: _____

DATE AND RESULTS OF LAST EXAMINATION: _____

If not performed:

☐ REASON: _____

[redacted]

TANNER STAGES: (Adolescents Only)

		Female	Male
☐	STAGE 1:	Preadolescent pubic hair and breasts.	Preadolescent penis and testes, no pubic hair.
☐	STAGE 2:	Sparse, lightly pigmented, straight pubic hair, breast and papillae elevated as small mounds.	Scanty pubic hair; slightly enlarged penis; enlarged scrotum, pink texture altered.
☐	STAGE 3:	Pubic hair darker, beginning to curl, increased amount; breasts and areolae enlarged, no contour separation.	Pubic hair darker and curly. Penis, scrotum larger.
☐	STAGE 4:	Pubic hair course, curly, more abundant; areolae and papillae form secondary mound.	Adult-type pubic hair; penis larger, wider; Scrotum larger, darker.
☐	STAGE 5:	Pubic hair is adult feminine triangle; mature breast, nipples project, areolae part of general breast contour.	Adult pubic hair distribution; full growth of penis and testes.

RECTAL: (All patients age 45 or older, or if specific symptoms indicate need for examination)

☐ INSPECTION: No evidence of hemorrhoids, fissures, bleeding or masses. Palpitation: In male, prostate is smooth, non-tender, free from nodules, is of normal size. Sphincter tone normal.

☐ SPECIFY OTHERWISE:

DATE / RESULTS OF LAST EXAMINATION:

☐ SPECIFY OTHERWISE:

If not performed:

☐ REASON: Not indicated

CIRCULATION:

☑ INSPECTION: **No significant varicosities.**

☑ PALPATION: **Pulses are palpable and regular in neck, wrist, groin, popliteal and tibial arteries.**

☑ AUSCULTATION: **No audible bruits**

☐ SPECIFY OTHERWISE:

EXTREMITIES:

☐ INSPECTION / PALPATION: **Full range of motion of joints. No discoloration, tenderness, edema or evidence of impaired function.**

☑ SPECIFY OTHERWISE: (R4) knuckle bruised MCP joint tender but ROM is good, flexion against resistance is painful

BACK:

☑ INSPECTION: There is normal curvature of the spine. Able to bend from waist.

☑ PERCUSSION / PALPITATION: There is no tenderness of the cervical, dorsal and lumbar spines.

☐ SPECIFY OTHERWISE:

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[redacted]

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[redacted]

HISTORY AND PHYSICIAL EXAMINATION

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Patient Identification

NEUROLOGICAL EXAMINATION:

Level of Consciousness:

☑ ALERT ☐ DROWSY ☐ STUPOR ☐ COMA
☑ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

Knowledge:

☑ APPROPRIATE TO AGE, EDUCATION, CULTURAL BACKGROUND, LIFE EXPERIENCES.

☐ SPECIFY OTHERWISE:_____

Speech and Language:

☑ CLEAR ARTICULATION.

☐ SPECIFY OTHERWISE:_____

Examination of Cranial Nerves:

Olfactory (CN 1):

☑ ABLE TO PERCEIVE FAMILIAR ODORS.

☐ SPECIFY OTHERWISE:_____

Optic (CN 2):

Visual Fields:

☑ FULL WITH NO DEFICITS ON CONFRONTATION; ABILITY TO DISTINGUISH NUMBER OF FINGERS IN CENTRAL FIELD, DISTINGUISHES MOVEMENT IN PERIPHERAL FIELDS.

☐ SPECIFY OTHERWISE:_____

Fundi:

☑ FLAT, DISCS NOT ELEVATED, NO ARTERIOVENOUS NICKING, NO HEMORRHAGES, NO RETINAL PIGMENTATION.

☐ SPECIFY OTHERWISE:_____

Pupillary Reactivity (CN 3):

☑ PUPIL SIZE SYMMETRICAL; PUPILS NEITHER WIDELY DILATED NOR PINPOINT IN AVERAGE ROOM LIGHT; PROMPT CONSTRICTION IN REACTION TO DIRECT LIGHT STIMULUS.

☐ SPECIFY OTHERWISE:_____

Movement of Eyes - Oculomotor (CN 3), Trochlear (CN 4), and Adbucens Nerves (CN 6):

☑ SMOOTH, SYMMETRICAL MOVEMENT THROUGH ALL POSITIONS OF GAZE, NO NYSTAGMUS PRESENT.

☐ SPECIFY OTHERWISE:_____

Eyelid Elevation (CN 7):

☑ ABLE TO RETRACT EYELID FULLY.

☐ SPECIFY OTHERWISE:_____

Trigeminal (CN 5) - Ophthalmic Branch, Maxillary Branch, Mandibular Branch:

☐ WITH EYES CLOSED, INDICATES FACIAL AND AURAL TACTILE PERCEPTION.

Movement of Muscles of Mastication:

☑ SYMMETRICAL TENSION IN MUSCLES OF CLENCHED JAW; ABLE TO MOVE JAW LATERALLY AGAINST RESISTANCE; SYMMETRICAL MUSCLE MASS OF TEMPORALS AND MASSATER; INVOLUNTARY CHEWING MOVEMENTS AND TRISMUS; CHEWS SYMMETRICALLY.

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☐ SPECIFY OTHERWISE:_____

[redacted]

NEUROLOGICAL EXAMINATION: (Continued)

Facial (CN 7):

☑ NORMAL FACIAL INSPECTION; FROWNS AND ELEVATES EYEBROWS SYMMETRICALLY, CLOSES EYELIDS TIGHTLY, ADEQUATE SALIVA PRODUCTION; ABLE TO SHOW TEETH; SMILES SYMMETRICALLY; ABSENCE OF LIP TREMORS.

☐ SPECIFY OTHERWISE:

Acoustics (CN 8):

Cochlear Branch:

☑ HEARS FINGER RUBBING AND SNAPPING EQUALLY IN BOTH EARS.

☐ SPECIFY OTHERWISE:

Vestibular Branch:

☑ FINGER-TO-NOSE OR FINGER-TO-FINGER WITHOUT PAST-POINTING; NORMAL TANDEM WALK; STANDS WITH FEET TOGETHER WITHOUT POSTURAL DEVIATION (Absent Romberg).

☐ SPECIFY OTHERWISE:

Glossopharyngeal (CN 9) and Vagus Nerves (CN 10):

☑ NORMAL MIDLINE ELEVATION OF UVULA AND PALATE; GAG REFLEX PRESENT; LARYNGEAL CONTOURS RISE WITH SWALLOWING; PHONATE WITHOUT HOARSENESS OR ARTICULATION DIFFICULTY.

☐ SPECIFY OTHERWISE:

Accessory Nerve (CN 11):

☑ NORMAL STRENGTH AND SYMMETRY ON TURNING HEAD AND ELEVATION OF SHOULDERS.

☐ SPECIFY OTHERWISE:

Hypoglossal Nerve (CN 12):

☑ TONGUE PROTRUDES IN MIDLINE WITH ABSENCE OF FASCICULATION, TREMORS OR ATROPHY; NORMAL MUSCLE STRENGTH OF TONGUE; NORMAL LINGUAL SPEECH.

☐ SPECIFY OTHERWISE:

CEREBELLAR FUNCTION:

Balance:

☑ NO ABNORMALITIES OF GAIT (Tandem and Heel-Toe).

Coordination:

☑ ABLE TO TOUCH FINGER-TO-NOSE AND HEEL-TO-SHIN RAPIDLY AND ACCURATELY WITH NO PAST-POINTING; ABLE TO PERFORM RAPID ALTERNATING MOVEMENTS (Suspination and Pronation of Forearms) QUICKLY AND SYMMETRICALLY.

☐ SPECIFY OTHERWISE:

MOTOR FUNCTIONS:

Muscle Tone and Mass:

☑ SYMMETRICAL ON INSPECTION, GOOD TONE WITHOUT SPASTICITY OR RIGIDITY; NO CONTRACTURE OR HYPOTONUS, NO ATROPHY.

☐ SPECIFY OTHERWISE:

Muscle Strength:

☑ ADEQUATE AND SYMMETRICAL MUSCLE STRENGTH (5/5) ON RESISTANCE TO OPPOSING FORCE FOR UPPER AND LOWER BODY MUSCLE GROUPS ON FLEXION AND EXTENSION, ABDUCTION AND ADDUCTION.

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☐ SPECIFY OTHERWISE:

[redacted]

[redacted]

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MOTOR FUNCTIONS (Continued):

Involuntary Movements:

☑ ABSENCE OF TREMORS, TWITCHES, TICS, FIBRILLATIONS, ATHETOID OR CHOREIFORM MOVEMENTS, MYOCLONUS OR MYOTONIA.

☐ SPECIFY OTHERWISE:_____

Range of Motions:

☑ FULL RANGE OF MOTION WITH NO RESTRICTIONS IN UPPER AND LOWER EXTREMITIES, SPINE.

☐ SPECIFY OTHERWISE:

Sensory System:

☑ NORMAL AND SYMMETRICAL RESPONSE TO TOUCH AND PIN PRICK.

☐ SPECIFY OTHERWISE:_____

OTHER REFLEXES AND SIGNS:

Babinski's Sign:

☑ ABSENT (Great Toes Down Going on Right and/or Left).

☐ PRESENT (Toes Up Going on Right and/or Left).

☐ NON REACTIVE OR EQUIVOCAL.

Meningeal Signs: absent

☐ PRESENT ☐ KERNIG ☐ BRUDZINSKI

Abdominal Reflexes:

☑ NORMAL ABDOMINAL REFLEXES.

☐ SPECIFY OTHERWISE:_____

Primitive Reflexes:

☐ PRESENT Describe:_____

Deep Reflexes:

Please Note Results of Tests of Biceps, Triceps, Radiohumeral, Quadriceps, and Achilles Reflexes.

0 = Absent 1 - Diminished 2 = Normal 3 = Increased 4 = Hyperactive 5 = Hyperactive with Clonus

	Left	Right
BICEPS	2	2
TRICEPS	1	1
RADIOHUMERAL	2	2
QUADRICEPS	2	2
ACHILLES	2	2

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[redacted]

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HISTORY AND PHYSICAL EXAMINATION

Clinical Impressions / Diagnoses:

① - MCP Strain (pt. hit fist) (Rt) hand
22-43.
Ice / motrin
② - Acute
③ - Tolerance inc. → Adv. to quit smoking.

Recommendations / Course of Action:

Medical Problems Which Should Be Addressed During This Episode of Treatment:

Medical Problems Which Should Be Addressed After Discharge:

Fu c Dr MJ

Patient Physically Able To Participate In All Aspects of Programming? ☑ YES ☐ NO
If not, list limitations:

[redacted]
Signature of Examiner

8/21/98
Date / Time

[redacted]
Signature of Attending Psychiatrist

8/21/98 2000
Date / Time

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[redacted]

[redacted]

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[redacted]

PSYCHOSOCIAL HISTORY - PART V

[redacted]

Patient Identification

INFORMANT: Chart, pt, RELATIONSHIP:

PATIENT'S CURRENT LIVING SITUATION: c (F) + (M) + 2 y.o. sister

ATMOSPHERE OF HOME: ☐ LOVING ☐ COMFORTABLE ☐ CHAOTIC ☒ ABUSIVE per pt. ☐ SUPPORTIVE
☐ OTHER:

1. **PRESENTING PROBLEM:** Pt is a 15 y.o. female admitted c ↑ depression ↓ sleep, ↑ anxiety. Pt admits to S.I.

2. **FAMILY OF ORIGIN**

PATIENT WAS RAISED BY: ☒ NATURAL PARENTS ☐ ADOPTIVE PARENTS ☐ GRANDPARENTS
☐ OTHER:

DESCRIBE RELATIONSHIP WITH CAREGIVERS: Pt states that her (F) is abusive to her physically. Pt. states that her (M) does nothing to support her or protect her from (F). (M) states relationship is stressful.

LIST THE NAMES AND AGES OF SIBLINGS AND WHETHER THEY ARE LIVING OR DECEASED: Sister (2 y.o.)

DESCRIBE RELATIONSHIP WITH SIBLINGS: Pt. close to sister

ATMOSPHERE OF CHILDHOOD HOME: ☐ LOVING ☐ COMFORTABLE ☐ CHAOTIC ☐ ABUSIVE ☐ SUPPORTIVE
☐ OTHER:

DISCIPLINE USED WITH PATIENT: pt states that her (F) physically abuses pt., grounding, removing privledges

SIGNIFICANT ISSUES FROM CHILDHOOD IMPACTING CURRENT ILLNESS: per (M) Denies

3. **FAMILY HISTORY OF PHYSICAL AND PSYCHIATRIC DISORDERS**

☐ FAMILY HISTORY INCLUDES SIGNIFICANT PHYSICAL ILLNESS. Describe: Denies

☒ FAMILY HISTORY INCLUDES SIGNIFICANT PSYCHIATRIC ILLNESS. Describe: uncle - manic depression + schizophrenia

☒ FAMILY HISTORY INCLUDES SUBSTANCE ABUSE. Describe: uncle - crack abuser

4. **MARITAL AND FAMILY RELATIONSHIPS**

PATIENT IS: ☒ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED Describe:

DOES PATIENT HAVE CHILDREN? ☐ YES ☒ NO If So, Name and Age:

(If Female Patient) DOES PATIENT HAVE A HISTORY OF ABORTION / MISCARRIAGE? ☐ YES ☒ NO

If So, Describe:

HOW HAS CURRENT ILLNESS AFFECTED FAMILY RELATIONSHIPS?

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[redacted]

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PSYCHOSOCIAL HISTORY - PART V

5. **HISTORY OF ALCOHOL AND DRUG USE** Denies

☐ PATIENT HAS A HISTORY OF ALCOHOL USE. Describe:

☐ PATIENT HAS A HISTORY OF DRUG USE. Describe:

☐ PATIENT HAS EXPERIENCED SYMPTOMS OF WITHDRAWAL WHEN ATTEMPTING TO DISCONTINUE USE.
Describe:

☐ PATIENT HAS A HISTORY OF INTRAVENOUS DRUG USE. Has Patient Ever Shared Needles? ☐ YES ☐ NO

☐ PATIENT HAS A HISTORY OF DRINKING / USING TO FEEL "NORMAL".

6. **HISTORY OF PHYSICAL / EMOTIONAL / SEXUAL ABUSE**

[redacted] ☐ OR ABUSING OTHERS.

☐ PATIENT HAS A HISTORY OF BEING SEXUALLY ABUSED. denies ☐ OR ABUSING OTHERS.

☐ PATIENT HAS A HISTORY OF BEING EMOTIONALLY ABUSED. ☐ OR ABUSING OTHERS.

7. **EDUCATION (Highest Level of Education Completed)**

☐ ELEMENTARY ☑ JR. HIGH ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

☐ OTHER: 9th grade ☐ LEARNING DISABILITIES Explain:

IS PATIENT CURRENTLY IN SCHOOL? ☑ YES ☐ NO

If Yes, How Has Current Illness Impacted Academic Performance: grades poor last year

If Yes, Name of School: CONTACT PERSON

8. **EMPLOYMENT / VOCATIONAL** Denies

☐ PATIENT IS WORKING. Where and How Long:

☐ PATIENT'S JOB HAS BEEN IMPACTED BY CURRENT ILLNESS. How:

☐ PATIENT'S EAP IS INVOLVED IN HIS / HER TREATMENT. Who is the EAP Representative:

☐ PATIENT HAS A HISTORY OF JOB INSTABILITY. Why:

☐ PATIENT REQUIRES ASSISTANCE FROM VOCATIONAL REHABILITATION AGENCY. Why:

9. **MILITARY** Denies

☐ PATIENT SERVED IN THE MILITARY. Which Branch, When, and Type of Discharge:

10. **LEGAL HISTORY (Arrests / DWI's / Probations / Pending Charges)**

☑ PATIENT HAS NEVER BEEN ARRESTED.

☐ PATIENT HAS BEEN ARRESTED. What Charge and When:

☐ PATIENT IS CURRENTLY ON PROBATION / PAROLE. Who is the Probation Officer:

☐ CURRENT ILLNESS HAS AFFECTED LEGAL HISTORY. How:

11. **SOCIAL SUPPORT SYSTEM**

☑ PATIENT HAS A SUPPORT SYSTEM. Describe Patient's Peer Group and Current Living Environment: Pt lives c (M) and (F). But pt. does not feel supported.

12. **CULTURAL INFLUENCES / RELIGIOUS BACKGROUND AND CURRENT ACTIVITY**

☑ PATIENT HAS A RELIGIOUS AFFILIATION. Name of Religion: Baptist

☐ PATIENT IS / (IS NOT) CURRENTLY ATTENDING A CHURCH Which Church:

☐ PATIENT'S AFFILIATION WITH A CHURCH IS PART OF HIS / HER SUPPORT SYSTEM.

☐ CURRENT ILLNESS HAS AFFECTED SPIRITUAL LIFE How: NA

☐ ETHNIC, CULTURAL FACTORS Describe:

[redacted]

[redacted]

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PSYCHOSOCIAL HISTORY - PART V

[redacted]

Patient Identification

13. FAMILY ASSESSMENT

☑ SIGNIFICANT OTHER INTERVIEWED? ☑ YES ☐ NO If No, Why:

☑ FAMILY / S.O. IS SUPPORTIVE OF PATIENT AND WILLING TO BE INVOLVED IN TREATMENT.

☐ FAMILY / S.O. IS UNWILLING TO BE INVOLVED IN TREATMENT. Why:

☑ FAMILY / S.O. EXPRESSES CONCERN ABOUT PATIENT. Describe: Per (M) states that pt. is extremly depressed. (M) states that she feels depressed over family problems.

☑ FAMILY / S.O. PERCEPTION OF ILLNESS.

14. GOALS FOR TX

AS IDENTIFIED BY PATIENT:

1.

2.

AS IDENTIFIED BY SIGNIFICANT OTHER:

1. Attitude toward parents

2. peer pressure

15. HISTORY OF PREVIOUS TREATMENT OR COMMUNITY MENTAL HEALTH RESOURCES USED (If different from Needs Assessment)

☑ OUTPATIENT THERAPY With Whom and When: Dr. [redacted] 2x.

☐ INPATIENT TREATMENT Where and When: none

☐ SELF HELP GROUP Which Groups and When: none

☑ MEDICATION MANAGEMENT Which Medications and When: Prozac, Adderall

OUTCOME OF ANY PREVIOUS TREATMENT:

16. DISCHARGE PLANS AND IDENTIFIED PROBLEMS

WHERE WILL THE PATIENT LIVE? ☐ HOME ☑ WITH FAMILY ☐ NEEDS PLACEMENT

☐ PARTIAL HOSPITAL PROGRAM ☐ ATTEND AFTERCARE ☑ FOLLOW UP WITH INDIVIDUAL THERAPIST:

☑ FAMILY THERAPY:

☐ OTHER:

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[redacted]

PSYCHOSOCIAL HISTORY - PART V

17. FINANCIAL RESOURCES Pt supported by parents

- ☐ PATIENT IS ABLE TO SUPPORT SELF WITHOUT ASSISTANCE.
- ☐ PATIENT REQUIRES REFERRAL FOR FINANCIAL AID.
- ☐ PATIENT REQUIRES REFERRAL FOR CREDIT COUNSELING.
- ☐ CURRENT ILLNESS HAS AFFECTED FINANCIAL SITUATION. How:

18. PATIENT STRENGTHS | PATIENT DEFICITS

19. DEVELOPMENTAL MILESTONES: At What Age Did Your Child First: (Child and Adolescent Only)

	YEARS	MONTHS		YEARS	MONTHS
SIT UP:	Development normal		SPEAK FIRST REAL SENTENCE:		
CRAWL:			BECOME COMPLETELY TOILET TRAINED:		
STAND ALONE:			HELP WITH HOUSEHOLD TASKS:		
WALK BY SELF:			RIDE A TRICYCLE:		
FEED SELF:			RIDE A BICYCLE:		
DRESS SELF:			TIE OWN SHOES:		
SPEAK FIRST REAL WORDS:					

PREGNANCY: ☒ PLANNED ☐ UNPLANNED DELIVERY: ☒ COMPLICATED ☐ UNCOMPLICATED

OTHER DEVELOPMENTAL INFORMATION ABOUT YOUR CHILD: 14 hours of labor lost heart beat - fetal distress.

20. HIGH RISK PSYCHOSOCIAL ISSUES REQUIRING EARLY TREATMENT PLANNING AND INTERVENTION(S)

I.e., UNATTENDED CHILDREN IN HOME, PRIOR NON COMPLIANCE TO SPECIFIC TREATMENT AND/OR DISCHARGE INTERVENTIONS, AND POTENTIAL OBSTACLES TO PRESENT TREATMENT AND DISCHARGE PLANNING:

None Specified

21. INTEGRATED SUMMARY AND RECOMMENDATIONS

INCLUDE SUGGESTED PROBLEMS TO BE ADDRESSED DURING THIS EPISODE OF TREATMENT ANTICIPATED OUTCOMES, TREATMENT, INTERVENTIONS: Pt is a 15 y.o. female admitted c ↑ depressive symptoms including SI. Pt. has attempted suicide last Dec. (Christmas night after ⓓ allegedly abused Pt). Pt. states that

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Social Services Signature

8/21/98
Date / Time

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